June 21 2006

Senator Nancy Sullivan
Representative Anne Perry
Joint Standing Committee on Insurance and Financial Services
100 State House Station
Augusta, ME 04333-0003

Re: Year 2005 Insurance Fraud Report

Dear Senator Sullivan, Representative Perry, and members of the Committee:

Pursuant to 24-A M.R.S.A. §2186, this letter constitutes the Bureau's Annual Report on Insurance Fraud to the Joint Standing Committee on Insurance and Financial Services.

This is the seventh year that insurers have been required to report on insurance fraud and abuse activities in Maine[1]. The Bureau has taken measures to ensure reporting compliance from licensed insurers by adding a reminder to the Annual Statement Instructions, offering completely automated on-line reporting, and sending reminder letters to some delinquent insurers.

This is the third consecutive year that the insurance industry has approached 100% reporting compliance. Prior to 2003, reporting compliance was considerably less than it is currently. Accordingly, great caution should be taken in comparisons between the last three years and earlier reporting years. Although the overall number of suspected fraud cases reported remained relatively steady from 2003 to 2004, there is an aggregate increase of nearly 45% in this year's report over the 2004 report. Significant increases appear in all lines except for workers' compensation. Reports of suspected workers' compensation fraud are down from 2004 and comparable to those reported in 2003.

With respect to health insurance, we note that one insurer's reported cases of health insurance fraud doubled between 2003 and 2005. Other carriers reported increases in suspected fraud at lesser rates. The reasons for the increase in the number of cases reported in 2005 are unknown to the Bureau.

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[1] For purposes of this report, "Fraudulent Insurance Act" has the same meaning as in 24-A M.R.S.A. §2186, sub-§1, paragraph A.
It includes the presentation or preparation of any information as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to a person engaged in the business of insurance regarding an application for insurance or for policy renewal, the rating of an insurance policy, a claim for benefits, payments made in accordance with an insurance policy or premium paid on an insurance policy

We would observe that there is an extensive body of literature noting the substantial cost of insurance fraud to Americans. A May 2005 online Federal Bureau of Investigation Report "Financial Crimes Report to the Public"[2] noted that estimates of fraudulent billings to health care programs, both public and private, are estimated to be between 3 percent and 10 percent of total health care expenditures. In 2004, health care expenditures were estimated at $2.1 trillion which represents 15.5% of the nation's Gross Domestic Product. The FBI Report cites Centers for Medicare and Medicaid Services (CMS) projections that health care costs in the United States are expected to exceed $3.1 trillion by 2012. Given the rate of inflation in health care costs, increases in health insurance fraud on the order noted in this year's report are alarming.

Increases in reports of suspected insurance fraud are also significantly up on the property and casualty side of the insurance industry. Reporting categories that show dramatic increases this year include inflating financial losses, providing an inaccurate or incomplete history or information in order to obtain coverage or to reduce an insurance premium and suspect claims including faking, exaggerating or extending the extent of disability. The Coalition Against Insurance Fraud website[3] cites multiple studies that show large numbers of persons say it is okay to defraud insurers or to "game" the system. The areas of dramatic increase seem not inconsistent with those attitudes.

According to the Bureau's fraud survey, the most common form of workers' compensation fraud in Maine is a faked or exaggerated injury, however, the overall number of cases in that category moderately decreased from 457 to 349 this year. Other forms of workers compensation fraud include employers who misrepresent the nature of their employees work or under report the number of employees or payroll figures in order to reduce their insurance premiums and medical providers that bill for more expensive products or procedures than those that were provided.

Property insurance had the third highest fraud and abuse count by line of business at 288 reported cases in this year's survey. According to the National Fire Protection Association, arson or suspected arson account for nearly 500,000 fires each year, or one in four fires in the United States. Arson and suspected arson are the largest causes of property damage in the U.S. In 2004 $879 million in U.S. property was destroyed by arson and 320 civilians were killed in arson fires.[4]

The Bureau of Insurance is receiving greater information and gaining a more detailed understanding of insurance fraud in Maine. In the coming years, further data will enable us to develop an increasingly accurate picture of the extent of insurance fraud and abuse in Maine.

If you have any questions concerning this report, please do not hesitate to contact me.

Sincerely,

Alessandro A. Iuppa
Superintendent

cc: Members, Insurance and Financial Services Committee
Lloyd R. LaFountain III, Acting Commissioner
Colleen McCarthy Reid, Legislative Analyst

[2] www.fbi.gov/publications/financial/fcs_report052005/fcs_report052005.htm
[3] www.insurancefraud.org/stats.htm
[4] www.iii.org/media/hottopics/insurance/test1

Maine Fraud and Abuse Annual Report
Seven Year Summary

Number of Suspected Cases of Fraud Reported by Line of Insurance

	2005	2004	2003	2002	2001	2000	1999
Automobile	1,058	800	768	516	348	260	262
Workers' Compensation	285	366	283	226	464	325	472
General Liability	86	50	66	26	33	39	15
Life	8	1	3	94	26	31	46
Health	369	76	90	46	75	122	72
Inland Marine	16	3	5	3	13	11	15
Property	288	165	190	72	81	92	89
Other Lines	40	27	50	429	486	220	24
Total	**2,150**	**1,488**	**1,455**	**1,412**	**1,526**	**1,100**	**995**

Maine Fraud and Abuse Annual Report

Types of Suspected Fraudulent Insurance Acts Reported

Claimant May Have:

Faked Property Damage	
1999	70
2000	74
2001	63
2002	34
2003	316 [1]
2004	323
2005	343

Inflated Financial Loss	
1999	65
2000	58
2001	101
2002	45 [2]
2003	150
2004	103
2005	146

Faked/Exaggerated Injury	
1999	530
2000	463
2001	374
2002	183 [2]
2003	539
2004	457
2005	349

Staged Accident/Injury	
1999	21
2000	20
2001	47
2002	21
2003	38
2004	53
2005	44

Been Known To File Suspect Claims, Including Faking, Exaggerating, or Extending Total or Partial Disability	
1999	53
2000	42
2001	78
2002	21
2003	60
2004	67
2005	172

Other	
1999	82
2000	157
2001	190
2002	510 3
2003	187
2004	157
2005	199

Legal Provider May Have:

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	2
2000	0
2001	0
2002	0
2003	0
2004	0
2005	0

Charged Fees Inconsistent with Services Provided	
1999	0
2000	0
2001	11
2002	0
2003	0
2004	0
2005	0

Other	
1999	4
2000	1
2001	0
2002	1
2003	1
2004	0
2005	1

Medical Provider May Have:

Provided an Inaccurate /Incomplete History	
1999	4
2000	6
2001	4
2002	0
2003	1
2004	23
2005	33

Billed for Services Not Provided	
1999	10
2000	15
2001	13
2002	2
2003	26
2004	27
2005	32

Upcoded or Billed for Excessive Treatments	
1999	233 [4]
2000	10
2001	24
2002	8
2003	23
2004	12
2005	47

Unbundled Services	
1999	1
2000	2
2001	0
2002	2
2003	1
2004	3
2005	33

Received Compensation for Referral to Medical or Legal Providers	
1999	3
2000	1
2001	0
2002	0
2003	0
2004	0
2005	11

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	10
2000	0
2001	0
2002	0
2003	0
2004	1
2005	0

Fabricated Services	
1999	3
2000	0
2001	11
2002	4
2003	10
2004	3
2005	3

Provided an Inaccurate/Incomplete History	
1999	0
2000	2
2001	1
2002	0
2003	0
2004	0
2005	0

Operated Without a License	
1999	0
2000	0
2001	1
2002	3
2003	1
2004	3
2005	57

Other	
1999	11
2000	7
2001	12
2002	11
2003	15
2004	13
2005	7

Other Person or Entity May Have:

Received/Paid Compensation for Referral	
1999	1
2000	0
2001	0
2002	0
2003	0
2004	0
2005	0

Fabricated Services	
1999	10
2000	1
2001	3
2002	1
2003	0
2004	0
2005	1

Charged Inconsistent with Services Provided	
1999	10
2000	10
2001	3
2002	0
2003	17
2004	0
2005	1

Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium	
1999	16
2000	11
2001	5
2002	29
2003	34
2004	42
2005	368

Other	
1999	18
2000	16
2001	12
2002	20
2003	13
2004	19
2005	2

Total Number of Suspected Fraud Claims by Line of Business:

Auto	
1999	262
2000	260
2001	348
2002	516
2003	768
2004	800
2005	1,058

Workers' Compensation	
1999	472
2000	325
2001	464
2002	226
2003	283
2004	366
2005	285

General Liability	
1999	15
2000	39
2001	33
2002	94
2003	66
2004	50
2005	86

Life	
1999	46
2000	31
2001	26
2002	94 [5]
2003	3
2004	1
2005	8

Health (Including Medicare/Medicaid)	
1999	72
2000	122
2001	75
2002	46
2003	90
2004	76
2005	369

Inland Marine	
1999	15
2000	11
2001	13
2002	3
2003	5
2004	3
2005	16

Property	
1999	89
2000	92
2001	81
2002	72
2003	190
2004	165
2005	288

Other	
1999	24
2000	220
2001	486
2002	429 [5]
2003	50
2004	27
2005	40

Total Number of Suspected Fraud Claims by Type of Insurance:

Personal	
1999	432
2000	626
2001	906
2002	712
2003	971
2004	875
2005	1,428

Commercial	
1999	563
2000	464
2001	622
2002	369
2003	387
2004	533
2005	713

Number of Cases Reported/Referred to Law Enforcement Agency:

District Attorney's Office	
1999	4
2000	34 [6]
2001	4
2002	63 [6]
2003	4
2004	8
2005	9

U.S. Attorney's Office	
1999	2
2000	5
2001	3
2002	0
2003	7
2004	4
2005	2

Other Law Enforcement	
1999	36
2000	16
2001	17
2002	12
2003	13
2004	57
2005	69

Workers' Compensation Board Abuse and Fraud Unit	
1999	0
2000	1
2001	1
2002	2 [2]
2003	21 [7]
2004	27
2005	31

National Insurance Crime Bureau	
1999	78
2000	95
2001	63
2002	14 [2]
2003	109
2004	230
2005	218

Other, Including U.S. Postal Authorities	
1999	18
2000	17
2001	149
2002	5 [2]
2003	3 [7]
2004	2
2005	1

Amount of Money NOT Paid on Suspected Fraudulent Cases:

Year	Amount
1999	$8,985,366
2000	$3,527,186
2001	$5,646,901
2002	$4,597,730
2003	$5,657,053 [8]
2004	$5,926,490
2005	$7,037,871

Notes

[1] An auto insurer with a growing market share in Maine reported that most of its suspected or confirmed fraud within the State of Maine occurs when a person applies for and receives auto coverage over the telephone and then reports a claim within 72 hours of securing coverage. Upon investigation, it is usually found that the accident occurred when the policyholder did not have coverage and lied about when the accident took place in order to have the insurance company pay for the loss. This insurer states that only 1% of its Maine claims were referred to an investigator.

[2] Several large carriers in Maine did not file reports for year-ending 2002.

[3] An auto insurer reported misrepresentations on applications to reduce premium (such as not listing all drivers in the household or not disclosing speeding tickets) in this category in this year but did not report this figure in years prior or subsequent.

[4] Workers' Compensation carriers were reporting cases where a physician submitted a bill for reimbursement and the amount submitted was higher than that which was allowed by statute. It was determined that the physicians were most likely billing their usual and customary fees, which just happened to be higher that the amount allowed by the Workers' Comp reimbursement tables. This is neither fraud nor abuse and was not reported in subsequent years.

[5] One national life insurance carrier reported fraud and abuse numbers on a national basis for many years. The Bureau worked with the company and only Maine numbers were filed this year. The company has been advised that in the future it should report Maine- only statistics.

[6] The same national life insurance carrier referred to in Note 4 would report all outside referrals in one category and this changed between 'District Attorney's Office' and 'Other' from year-to-year. The company has been advised that it needs to report on a consistent basis between years.

[7] A workers' compensation carrier used to report its outside referrals in the 'Other' category and then changed to the 'Workers' Compensation Board Abuse and Fraud Unit' category in 2003 because it better suited where the referrals were sent. The company will use reporting consistent with 2003 in future years.

[8] One insurer amended its 2003 report in 2005 to show $445,434 instead of $10,445,434 as originally reported.